BIPA 2001 Questions and Answers

February 1, 2001

ACRP

1. Q: Must ALL ACRPs for CY 2001 be resubmitted?

A: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) specifically says that if any part of an M+C plan's service area includes a payment area for which the M+C capitation rate is higher than the rate previously determined, the M+CO shall revise its submission. We anticipate all service areas receiving a payment increase, and therefore, ALL current, HCFA-approved CY 2001 ACRPs must be resubmitted.

2. Q: What is the deadline to submit revised/new ACRPs?

A: The deadline to submit either revised CY 2001 ACRPs for current plans or new ACRPs for M+COs returning to the M+C program or re-entering a previously reduced service area is midnight on January 18, 2001. Specifically, electronic versions of ACRs and PBPs must be uploaded to HPMS by midnight, January 18, whereas paper copies of ACRs must be postmarked by January 18.

3. Q: If an M+CO renewed its M+C contract in July 2000, when does a revised ACR (submitted in January 2001) become effective and what time period does it cover?

A: A revised ACR submitted in January will be an addendum to the approved ACR and will continue to cover the 12-month period beginning January 1, 2001 and ending December 31, 2001. The new payment rates and required changes in benefits, premiums, and cost sharing will be effective March 1, 2001. (See question #17 of this section for more detailed information.)

4. Q: What modifications to ACRPs are permitted by BIPA?

A: M+COs may make one or more of the following changes:

- reduce beneficiary premiums,
- reduce beneficiary cost sharing,
- enhance benefits,
- put additional payment amounts received after March 1 in a benefit stabilization fund, or
- use additional payment amounts to retain providers (stabilize access) or expand the provider network (enhance access), so long as this stabilization or enhancement does not result in increased premiums, increased cost sharing, or reduced benefits.

5. Q: If an M+CO reduces premiums or cost sharing or enhances benefits in a revised ACRP effective March 1, what premium and cost sharing should be charged and what benefits should be offered in January and February?

A: The premium, cost sharing, and benefits in a current HCFA-approved ACR will be collected/offered in January and February. For example, if a plan effective January 1, 2001 contains a $50 premium whereas the revised plan effective March 1 contains a $25 premium,

$50 must be collected from each enrollee in January and again in February. $25 must be collected each month from each enrollee March through December.

6. **Q: If an M+CO wishes to use a stabilization fund, where can more information on such a fund be obtained?**

   A: Qs&As on the stabilization fund are located below in the section labeled "Stabilization Fund".

7. **Q: Are M+COs required to sign new contracts or amend current contracts as a result of the BIPA?**

   A: M+COs returning to the M+C program for CY 2001 must sign a new M+C contract in advance of the effective date. The new contracts will reflect any new program requirements created by BIPA. M+COs re-entering a previously reduced service area will be required to agree to amend their contracts at Attachment D to include the new counties they will serve. In both of these cases, HCFA will send each applicable M+CO a new contract or modified contract agreement once notification is received of an M+CO's intent to return to the M+C program or re-enter a previously reduced service area. In addition, the M+COs identified here must return their 2001 contracts in advance of the effective date.

8. **Q: Are M+COs permitted to update their currently approved ACRs with more recent and accurate data?**

   A: To the extent changes would result in stabilizing or enhancing access to providers or relate to new benefits, such changes are permitted. For example, updates to direct medical costs could include revised utilization, unit cost, demographic, enrollment, and trend assumptions. Demographic and enrollment assumptions can be updated in the APR calculation and changes to the initial rate are also permitted. Increases to administrative costs are prohibited unless the increase has a significant direct relationship to stabilizing or enhancing beneficiary access to providers or directly related to enhanced benefits. Changes in assumptions concerning additional revenue are not permitted unless directly related to enhanced benefits. Changes to the base period costs on Worksheets A or B or the financial data on Worksheet B-1 are also not permitted.

9. **Q: What information should I include in the cover letter that accompanies the ACR?**

   A: A cover letter should accompany the hard copy submission of the ACR. M+COs must include the previously approved Average Payment Rate (APR), the new APR (using the higher rates calculated under BIPA only), and a summary list detailing how the increased payment will be used. Following are examples of items to include in the detailed list on how the increase in payment will be used: reducing the premium from $50 to $25, reducing the physician copay from $20 to $10, adding a prescription drug benefit with a $500 annual maximum, etc. Resolutions of issues during the prior desk review process and any other pertinent information the M+CO wishes to make HCFA aware of concerning the resubmission of the ACR under BIPA should also be included.

10. **Q: If an M+CO chooses not to update approved ACRs with more recent data, will they still be in compliance with the certification statement that appears on Worksheet A of the ACR?**

A: Yes, if an exception statement is added to the cover letter. The certification statement that appears on Worksheet A of the ACR says: ". . . To the best of my knowledge and belief, this proposal contains true and correct statements prepared from the books and records of the contracting organization in accordance with applicable instructions, ***except as noted*** . . ." Exceptions to this certification should be noted in the cover letter. We suggest a statement similar to the following be included: *"<ABC Co.> is electing not to update projections or assumptions, but is only making the changes required by BIPA"*.

11. Q: Will new ACR worksheets be provided?

A: No, M+COs must use the current version of the ACR (V2001.6) and begin making changes using the latest HCFA-approved version of the ACR and PBP. M+COs that have submitted mid-year benefit enhancements and/or plan corrections that have been approved should use the most recently-approved version. If you prefer to start with a clean ACR worksheet, you may download one from HPMS.

12. Q: Can an M+CO delete any currently approved M+C plans?

A: No, during the BIPA 2001 season, M+COs cannot delete M+C plans that have been approved by HCFA. The current plan structure must be maintained.

13. Q: Can an M+CO add plans using the currently approved service area under BIPA? For example, if an M+CO offers one plan covering two counties, can it now offer two plans, each covering one county?

A: No, pursuant to BIPA, new plans can not be added using the currently approved service area. The current plan structure must be maintained.

14. Q: Is it permissible to change or rearrange the service area-to-plan relationship under BIPA? For example, an M+CO offers 2 plans – plan 1 covering counties A & B and plan 2 covering county C. Can the M+CO rearrange the service area so that plan 1 will cover county A and plan 2 will cover counties B & C?

A: No, M+COs cannot change the existing assignment of the service area to currently approved M+C plans. Under BIPA, the current plan structure must be maintained.

15. Q: What are the consequences of any M+CO being unwilling or unable to file a revised ACRP by the deadline of January 18?

A: If an M+CO who renewed its contract in July 2000 for CY 2001 fails to timely submit a revised ACRP, HCFA will automatically place the additional payment in a stabilization fund for the plan effective March 1. In addition, sanctions can be imposed for non-compliance. We will continue to accept new M+C applications and service area expansion applications after January 18.

16. Q: If an M+CO's CY 2000 ACR was audited, can those items identified as audit findings be corrected in a revised submission of a CY 2001 ACR?

A: Yes, those items identified as findings in the audit of the CY 2000 ACR may be corrected in a revised submission of a CY 2001 ACR. However, such corrections are not required.

17. Q: Since the ACR covers the 12-month period beginning January 1, 2001 and ending December 31, 2001, but the change in benefits and cost sharing is not effective until

March 1, how should I enter the data in the ACR & PBP?

A: All values entered in the ACR & PBP should reflect the premium, cost sharing, and benefits that will be effective beginning March 1. The Average Payment Rate (APR) on Worksheet A1 should be calculated using only the new, higher rates provided for under BIPA. The information that currently resides on Worksheet A1 would remain and adjustments must be made to produce the APR at BIPA rates. This can be done in one of two ways. An adjustment can be made to the "plan-level adjustment" column (column j) or an unassigned county (code 99999) may be added. To add an unassigned county, enter 99999 into column a. Then enter a payment value in column c and a membership value in column l that would result in an APR at the new, higher BIPA rates. Changes to Worksheets A, C, and D should be made pursuant to BIPA (see question #4 of this section). The premium entered in the ACR should match the premium in the PBP. No weighting of any values is necessary.

18. **Q: If I did not renew my contract or reduced my service area in July 2000 for CY 2001 and I wish to return to the M+C program or re-enter the previously reduced service area, must I return to the entire service area covered in CY 2000?**

    A: No, M+COs returning to the program or re-entering a previously reduced service area can return to all or part of the CY 2000 service area provided that they attest to the adequacy of their network. (A network adequacy attestation form is available on the HCFA website at: www.hcfa.gov/medicare/cy2001.htm.).

    If the M+CO's CY 2000 service area included a partial county, then the M+CO may return to that partial county. If the M+CO's CY 2000 service area included a full county and the M+CO would like to return to only part of that county, then the M+CO must submit its request to HCFA as soon as possible and demonstrate that the request meets the criteria outlined in Operational Policy Letter 99.090. M+COs should not submit their ACRP until HCFA approves or disapproves the request. HCFA will make every effort to review and approve or disapprove each request so that the M+CO can submit its ACRP prior to January 18, 2001. However, given the short timeframes allowed for review of these requests, some requests may not approved in time for the M+CO to submit its ACRP by January 18 for a March 1 effective date. In these cases, the M+CO will still be able to submit its ACRP once HCFA approves its request, but the ACRP would not be effective until after March 1.

19. **Q: Why is it important that I notify HCFA in a timely manner if I plan to return to the M+C program or re-enter a previously reduced service area?**

    A: Upon receipt of written notification from an M+CO that wishes to return to the M+C program or to re-enter a previously reduced service area, HCFA will make the appropriate actions in the HPMS non-renewal/service area reduction module to permit M+COs to create one or more new plans covering the newly available county or set of counties and to download the new ACR(s) and PBP(s). If HCFA does not receive the written notification in a timely manner, the process of creating plans and downloading the ACR(s) and PBP(s) will be prohibited until HCFA receives such notice. This reduces the amount of time an M+CO has to complete its ACR(s) and PBP(s).

20. **Q: Whom do I contact if my HPMS password needs to be reset?**

    A: Please contact Don Freeburger at either 410-786-4586 or DFreeburger@hcfa.gov.

21. **Q: Whom do I contact for technical assistance on the HPMS while preparing and submitting my ACRPs?**

    A: Please contact the HPMS Help Desk at either 1-800-220-2028 or hpms@nerdvana.fu.com.

22. **Q: Whom do I contact for technical assistance on the ACR worksheets?**

    A: Please contact LMI at either 703-917-7236 or jo'keiff@lmi.org.

23. **Q: Where can I find the new payment rates provided for under BIPA?**

    A: www.hcfa.gov/stats/hmorates/aapccpg.htm

24. **Q: Are certification signatures required on each and every ACR submitted?**

    A: Yes, the CEO, CFO, and VP of Marketing must sign each and every ACR submitted under BIPA. For ACRs that must be resubmitted after the initial BIPA resubmission, refer to page 18 of HCFA's ACR instructions to determine when the certification on Worksheet A must be completed.

25. **Q: What documentation must accompany the ACR, especially with regards to documenting the use of additional payment to stabilize or enhance the provider network?**

    A: M+COs that are returning to the M+C program or are re-entering a previously reduced service area must submit a new ACRP with a full set of written, supporting documentation. See the BIPA ACRP instructions for a complete list of requirements. Organizations re-submitting HCFA-approved plans must submit substantiation only for those items that changed from the approved version. If all or part of the additional payment is used to stabilize or enhance the provider network, a narrative is acceptable. The narrative should state clearly how those funds "stabilize" or "enhance" the provider network and the PMPM amount attributable to this use.

26. **Q: How do I reflect the new Medicare-covered benefits in the ACR and PBP?**

    A: Include the additional cost for the new Medicare benefits in the ACR as an expected variation on Worksheet D. Also, you can add additional language to the note fields in the PBP.

27. **Q: Must I resubmit ACRPs for Part B-only plans? What if I no longer have any Part B-only members?**

    A: All ACRPs must be resubmitted, including those for Part B-only plans. However, if an M+C plan no longer has Part B-only members, a resubmission of the Part B-only ACRP(s) is not required. Instead, the M+CO must notify HCFA by January 18, in writing, of which of its M+C plans no longer has Part B-only members.

28. **Q: Since the statute does not distinguish between types of premiums that may be reduced, is a reduction in premium for an optional supplemental benefit or mandatory supplemental benefit permissible?**

A: No, M+COs cannot use increases in the payment rate to reduce premiums for supplemental benefits. The payment received from HCFA covers Medicare-covered and additional benefits, but not mandatory supplemental or optional supplemental benefits. However, an M+CO can move a benefit from either the optional supplemental or the mandatory supplemental benefit category to the additional benefit category. In addition, an M+CO can reduce premiums for supplemental benefits if it does not use government payments to cover the reductions.

29. **Q: Is an M+CO permitted to enter a capacity limit on the ACR to be submitted under BIPA?**

    A: Yes, an M+CO may enter a capacity limit on an ACR to be submitted under BIPA. However, approval of the ACR does not mean the capacity limit is approved. A capacity limit can be requested at any time during the year, but the approval process for capacity limits is separate from the ACR approval process (see OPL 99.095 for more information.) In addition, requesting a capacity limit does not fulfill the requirements under BIPA for use of the additional payment.

30. **Q: We have discovered that the initial rate in our approved ACR is understated and wish to update it in our submission under BIPA; however doing so would increase the non-Medicare additional revenue and the instructions state that additional revenue can not increase from the current approved PMPM value. In this case, can the Medicare additional revenue increase accordingly?**

    A: The initial rate for the contract period on Worksheet A, Part IB, column b can be adjusted to reflect a more accurate estimate that may result in an increase in additional revenue for non-medicare enrollees; However, in this particular situtation, the additional revenue PMPM amount on Worksheet D for Medicare enrollees must not exceed the PMPM amount that HCFA previously approved for CY 2001. In other words, a negative adjustment must be made on Worksheet D to ensure that the new value does not exceed the approved additional revenue value (i.e., cannot be a bigger positive amount or a smaller negative amount than HCFA has approved). Of course, as explained in the answer to Question 8, additional revenue PMPM amounts can be increased if the increase is directly related to enhanced benefits.

31. **Q: Can an M+CO increase some cost sharing and decrease other cost sharing as long as the total PMPM value is the same? For example, if a plan has an approved $10 generic drug copay and a $20 brand name drug copay, could the copays be changed to $5 generic and $25 brand if it could be shown that this design has the same PMPM value as the approved ACR?**

    A: No, cost sharing can not increase for a currently approved benefit. Though the PMPM value does not change on an average basis, cost sharing would be increased on an individual basis.

32. **Q: Can an M+CO use the increase in payment to reduce or eliminate projected losses?**

    A: No, the increase in payment CANNOT be used to reduce or eliminate projected losses. In other words, the approved additional revenue PMPM value can NOT be increased in the ACR submitted under BIPA unless the increase is directly related to enhanced benefits.

33. Q: Can the adjusted community rate (ACR) for an M+C plan exceed its average payment rate (APR)?

A: No. With respect to column a of Worksheet E (Part I), the "Adjusted ACR"(line 8) *cannot* exceed the "Average Payment Rate" (line 1). If line 8 exceeds line 1, make the two values equal by reducing the ACR. Do that *only* by making a negative adjustment on ACR Worksheet D in the expected variation cell, line 24ev under column b ("Adjusted Value Medicare-Covered Benefits"). For example, if line 8 on Worksheet E Part I is $500 and line 1 above it is $490, enter an expected variation of negative $10 in column b, line 24ev of Worksheet D.

If you are resubmitting an HCFA-approved ACRP under BIPA where the ACR exceeds the APR, make the adjustment described above *before* you do the rest of your BIPA-related adjustments. Equalizing the ACR and the APR at the beginning of your calculations will help to ensure that safeguards built into the electronic Worksheet E don't keep you from entering a contribution to a stabilization fund. (HCFA has *not* customized the current version (V2001.6) of Worksheet E for BIPA purposes. Many M+COs wanted to use that version of the ACR workbook to avoid the need to enter previously approved ACR data into a new version.)

If your plan ACR exceeds its APR

- after making all of your adjustments to your previously approved ACR, or
- in an ACR for a new M+C plan,

make the adjustments to additional revenue as described in the first paragraph above.

34. Q: Can an M+CO returning to the M+C program or re-entering a previously reduced service area have a CY 2001 service area that is larger than its CY 2000 service area?

A: Yes. However, the M+CO must apply for a service area expansion that HCFA would then review in accordance with its standard application review procedures for such expansions.

35. Q: Is the approval of an ACRP filed under BIPA contingent upon meeting provider network requirements?

A: All M+COs that choose to return to the M+C Program or re-enter a previously reduced service area must complete and return a Network Adequacy Attestation Form to the appropriate HCFA Regional Office. (This form is available at: www.hcfa.gov/medicare/cy2001.htm.) HCFA reserves the right to request additional information about the M+CO's provider networks prior to approving the ACRP.

36. Q: Did BIPA extend the bonus payment program to counties in which there were M+C plans offered in 2000?

A: Yes. Under the Balanced Budget Refinement Act (BBRA) bonus provisions in Section 1853(i)(1), an M+CO was only entitled to a bonus if all M+C plans offered in the county had been non-renewed effective January 1, 2000. (See HCFA regulations at 42 CFR 422.250(g) and Operational Policy Letter (OPL) 117.) BIPA amended Section 1853(i)(1) by changing the January 1, 2000 date to January 1, 2001. This change was made retroactively as if enacted as part of BBRA. Thus, M+C organizations offering M+C plans in counties in which M+C plans were offered in 2000 are eligible for a bonus if all plans offered in 2000

were non-renewed for 2001. With the exception of this change in dates, the same policies in section 422.250(g) and OPL 117 continue to apply.

37. **Q: An M+CO notified HCFA in July 2000 that it would no longer offer its M+C plan for 2001 in a county in which all other M+C plans were also non-renewed for 2001. Is the M+CO entitled to bonus payments if it reenters the county as the first organization to offer an M+C plan in the county in 2001? What if it first offers the plan on the same day as another M+CO?**

    A: Under BIPA, as long as any M+C plans offered in a county were non-renewed for 2001 prior to October 3, 2000, the first M+CO offering a plan in that county (or, any M+COs first offering an M+C plan in the county the same day) is eligible for bonus payments, even if the organization(s) were among those that previously non-renewed an M+C plan offered in 2000.

38. **Q: Should M+COs include bonus payments in determining their obligation to provide additional benefits?**

    A: No. As in the case of the existing BBRA bonus program, bonus payment amounts do not need to be considered in determining the extent of an M+CO's additional benefit obligations, including the new obligations resulting from the payment increase in BIPA.

39. **Q: An M+CO that non-renewed its M+C plan would like to return to the M+C Program and offer an M+C plan for 2001. If the M+CO submits its ACRP by January 18, 2001, can it offer the M+C plan effective April 1, 2001 instead of March 1, 2001?**

    A: Yes. Section 604(b) of BIPA allows an M+CO to reenter the M+C program as long as an ACR proposal is submitted by January 18, 2001. The effective date of the M+C plan may be set on the first of any month in calendar year 2001.

40. **Q: An M+CO that non-renewed its M+C plan would like to return to the M+C Program and offer an M+C plan for 2001. M+CO notified HCFA in July 2000 that it will no longer offer its M+C plan. However, the M+CO will not be able to submit its ACR proposal by January 18, 2001. Can the M+C organization offer the M+C plan effective April 1, 2001 instead of March 1, 2001?**

    A: HCFA will treat the M+CO as though it is offering a new M+C plan (not as an M+CO re-entering the program under BIPA) and will require the organization to comply with HCFA's standard application procedures. If there is sufficient time to complete this process, HCFA could sign a contract with the M+CO effective April 1, 2001 and the organization would re-enter the program on April 1, 2001.

Stabilization Fund

1. **Q: What is the stabilization fund?**

    A: The stabilization fund is a monetary reserves held by the federal government on behalf of Medicare+Choice organizations (M+COs) for the Medicare enrollees of a specific M+C plan. The fund is financed from amounts that individual M+COs ask HCFA to withhold from government payments due on M+C contracts.

2. **Q: For what can money placed in the stabilization fund be used?**

A: The money can be withdrawn by the contributing M+CO to stabilize and prevent undue fluctuations in "additional benefits" of the M+C plan that originally contributed to the fund.

3. **Q: Is advance notice required for deposits to and/or withdrawals from the stabilization fund?**

   A: Yes. Requests for HCFA approval of contributions and withdrawals generally must be made in the annual adjusted community rate proposal (ACRP) submissions. Contributions may also be made in a revised ACRP submitted pursuant to the Benefits Improvement and Protection Act of 2000 (BIPA), as discussed in Question 22 below.

4. **Q: Will the government hold amounts deposited in the stabilization fund indefinitely on behalf of M+COs?**

   A: No. The government will hold fund amounts reserved for a specific M+CO until the M+CO withdraws all of the reserved funds, terminates the M+C plan that established the fund, or until the expiration of the holding period specified by the M+CO, whichever comes first.

5. **Q: Do government regulations limit the amount that my M+CO may have withheld for any M+C plan?**

   A: Yes. Generally HCFA will not approve requests for withholding under a specific adjusted community rate (ACR) for a specific contract period if the requested amount would 1) exceed 15 percent of an M+C plan's excess amount for the contract period and/or 2) cause the total cumulative amount in the stabilization fund for a specific M+C plan to exceed 25 percent of the excess amount for that plan for that contract period. However, federal regulations provide for an exception to the 15 percent limit. See Question 22 below for discussion of an additional exception to the above limits provided for in BIPA.

6. **Q: Do federal regulations authorize an exception to the 25 percent cumulative limit on withholding for a plan's stabilization fund?**

   A: No. However, see Question 22 below for an additional explanation of this general rule.

7. **Q: Can my M+CO withdraw money from its stabilization fund whenever it wants?**

   A: No: Advanced notice is required, and the conditions listed in 42 CFR 422.312©(5) must be met. Briefly, these conditions are:

   - The average payment rate (APR) of an M+C plan is decreasing;
   - The M+C plan's ACR is significantly increasing;
   - The value of additional benefits reported in the current ACR submission is significantly increasing over the value of additional benefits reported in the previous ACR submission; or,
   - The modified ACR (ACR for Medicare covered benefits less the actuarial value of Medicare's Deductibles and coinsurance) is increasing at a faster rate than the M+C plan's APR.

   The M+CO must notify HCFA of its intent to withdraw money from its stabilization fund in the ACR for the plan associated with the stabilization fund. HCFA will not allow a

withdrawal from the stabilization fund if the money is used to refinance prior contract period losses or only to avoid losses in the upcoming contract period.

8. **Q: How does the government record reserved funds?**

   A: Reserved funds are held in a stabilization fund uniquely identified to *each* participating M+CO and within that, reserved funds are uniquely identified to *each* participating M+C plan. Within each stabilization fund, annual contributions and withdrawals are recorded separately by M+C plan to account for the holding period specified in the relevant ACR.

9. **Q: Must an M+CO use its reserved funds exclusively for stabilizing additional benefits for the M+C plan under which the funds were withheld?**

   A: Yes. To the maximum extent possible, reserved funds must be used to benefit the Medicare enrollees of the M+C plan under which the funds were originally withheld.

10. **Q: If my M+CO requests withholding for a stabilization fund from the same M+C plan in different contract years, must it specify the same holding period?**

    A: No.

11. **Q: Under normal circumstances not pursuant to BIPA, I understand that federal regulations permit an exception to the 15 percent limit on annual withholding to finance a plan's stabilization fund. How will HCFA implement the exception?**

    A: HCFA will require M+COs applying for the exception to demonstrate, using *actual* data, that the additional benefits provided to Medicare enrollees electing the plan varies by more than the 15 percent limit from year to year. See Question 22 below for discussion of an additional exception to the above limits provided for in BIPA.

12. **Q: Is the authorized exception to the 15 percent limit on annual withholding for a plan's stabilization fund available to new M+CO plans?**

    A: No. See Question 22 below for discussion of an additional exception to the above limits provided for in BIPA.

13. **Q: My M+C organization wants to withdraw funds withheld for an M+C plan we no longer offer. How should we document that request?**

    A: If your organization terminated the M+C plan, the amount in the stabilization fund reserved for that plan would have been forfeited to the Medicare trust funds.

14. **Q: My M+C organization wants to withdraw funds withheld for an M+C plan, but we plan to drop out of the M+C program next year. How do we get the funds back?**

    A: If your M+C plan meets one of the conditions outlined in question 7, The organization may withdraw money from the stabilization fund. However, if your organization terminated the M+C plan, the amount in the stabilization fund reserved for that plan would be forfeited to the Medicare trust funds.

15. **Q: After my company's ACR for an M+C plan has been approved, can we change the level of contributions we proposed to make to the stabilization fund?**

    A: No.

16. **Q: After my company's ACR for an M+C plan has been approved, can we change the amount proposed for withdrawal from a stabilization fund?**

    A: No.

17. **Q: If my company has a stabilization fund, can it choose to avoid contributing to or withdrawing from it during a specific contract period.**

    A: Yes. Regulations generally don't force you to take any specific actions related to your reserved funds. However, if your fund-holding period(s) would expire during that contract period, you should consider, if you meet the conditions outlined in question 7, withdrawing the reserved funds. Otherwise, they will be forfeited to the Medicare trust funds when the holding period expires.

18. **Q: My organization wants to withdraw reserved funds during the next contract period, but we don't expect to offer any additional benefits in our M+C plan. Can we withdraw reserved funds?**

    A: It depends. The M+C plan must meet at least one of the conditions outlined in question 7 in order to withdraw from the stabilization fund.

19. **Q: When can M+C organizations withdraw amounts from the stabilization fund?**

    A: The reserved funds can be withdrawn by a contributing M+CO in contract periods after the ones during which the reserves have been deposited.

20. **Q: Can an M+CO both contribute and withdraw reserved funds during a contract period?**

    A: Yes, but only if the M+CO has more than one M+C plan and the contributions and withdrawals relate to different M+C plans offered by the M+CO. In other words, M+COs can have more than one M+C plan and thus, can have more than one stabilization fund. Each stabilization fund is related to a specific M+C plan. Therefore, assuming an M+CO with multiple M+C plans in a specific contract year, one of its plans can contribute to the plan's stabilization fund while another of its plans can withdrawals from the latter plan's stabilization fund.

21. **Q: My organization offers more than one M+C plan. We will reserve funds in a stabilization fund for one of our plans during contract year 2001. Do we have to reserve funds in our other plans?**

    A: No.

22. **Q: In accordance with the passage of the Beneficiary Improvement and Protection Act (BIPA), HCFA's payments for the M+C plan offered will increase. My company would like to contribute the entire increase in M+C plan payments to the stabilization fund. This contribution should increase the M+C plan stabilization fund balance greater than the limit (25% of excess amount). Will HCFA allow this contribution? Next year, will the M+C plan be able to contribute any more money to the stabilization fund?**

    A: The BIPA requires M+C organizations to submit or revise its ACRs for calendar year 2001. Section 604 waives all limits associated with the stabilization fund for these ACRs.

Therefore, an M+C organization may contribute all or part of the increase in payments for a particular M+C plan into a stabilization fund. In subsequent years, M+C organizations will not be allowed to make additional contributions to an M+C plan's stabilization fund until the balance remaining in that fund is less than the 25% of the excess amount limit for that plan.

Full Implementation of Risk Adjustment for CHF Enrollees for 2001

1. **Q: What does "full implementation of risk adjustment for CHF" mean?**

   A: Payments for beneficiaries with a qualifying diagnosis will be made at 100 percent of the risk adjustment method's amount for Congestive Heart Failure (CHF). This payment is only for calendar year 2001 and is available only for enrollees in the only coordinated care plan in the area. A qualifying CHF diagnosis is defined as a principal inpatient discharge diagnosis of CHF (ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x) for a beneficiary who had a hospital inpatient stay greater than one day, between July 1, 1999 and June 30, 2000.

2. **Q: How will HCFA determine that an M+CO is the only coordinated care plan in the service area of an individual?**

   A: The service area for an enrollee is defined at the county level. An M+CO will receive the full risk adjusted CHF payment for an enrollee in 2001 who has a qualifying CHF diagnosis between July 1, 1999 and June 30, 2000 who resides in a county where only one coordinated care plan is offered.
   For example, if the M+CO is the only coordinated care plan in 2 out of the 7 counties where it is offered, then the M+CO will receive the full risk adjusted CHF payment for each enrollee with a diagnosis of CHF residing in those 2 counties, i.e. the service areas of the individuals. The M+CO would not be eligible for fully risk adjusted payment in the other 5 counties because there are other coordinated care plans offered in those counties.
   If more than one M+CO is offering a coordinated care plan in an enrollee's county, but the other M+COs have capacity limits and have closed enrollment in their coordinated care plans, then the remaining M+CO is not eligible for the full implementation of risk adjustment for its CHF enrollees. M+COs that have closed enrollment can choose to open their enrollment at any time.

3. **Q: Is this full implementation of risk adjustment for CHF only for those with a principal inpatient discharge diagnosis of CHF?**

   A: Yes. As referenced in the statute, we will implement this payment for CHF in 2001 consistently with the Principal Inpatient Diagnostic Cost Group (PIP-DCG) risk adjustment methodology now used in the Medicare+Choice program. This methodology pays only for the highest principal inpatient diagnosis for an enrollee who had a hospitalization in the prior year. We will pay the higher of 100 percent of the CHF (PIP-DCG 16) or the amount that would apply under risk adjustment in 2001 (10 percent risk adjustment, and 90 percent demographic adjustment only). In all possible cases, the highest payment will be 100 percent of the CHF amount.
   For example: A beneficiary enrolled in a M+CO has a hospitalization with a qualifying CHF diagnosis and another hospitalization with a diagnosis of AIDS. In this case, the M+CO is paid 100 percent of the PIP-DCG 16 amount for CHF because it is higher than a payment

reflecting 10 percent of the PIP-DCG 29 amount for AIDS (and 90 percent based on demographic factors only).

4. **Q: Is this "full implementation of risk adjustment for CHF in 2001" BIPA provision related to the Quality Assessment Performance Improvement (QAPI) CHF project and extra payment in recognition of successful outpatient CHF care activity which begin in 2001, described in Operational Policy Letter 2000.129?**

   A: No. The BIPA provision is unrelated to the CHF projects announced in OPL 2000.129. The QAPI project is a required quality improvement project for all M+COs and is not associated with payment. The BIPA provision applies to payment only for 2001 and only for enrollees in areas with only one coordinated care plan. By contrast, the extra payment in 2002 will be made to all M+COs who qualify for the extra payment based on successful outpatient care. In addition, the extra payment in 2002 is consistent with the risk adjustment phase-in schedule, which provides for 10 percent risk adjusted payment in 2002 (and 90 percent based on demographic factors only).

5. **Q: When should M+COs expect payment for the full implementation of risk adjustment for CHF?**

   A: Because of payment systems changes required to make payments for the full implementation of risk adjustment for CHF, M+COs may expect the payment in the second quarter of calendar year 2001. Payments will be retroactive to January 2001. M+COs may expect payment during this timeframe only if HCFA received the encounter before September 30, 2000. Otherwise, extra payments will be made for 2001 during the reconciliation process in 2002.

Marketing Material Review

1. **Q: The Benefits Improvement and Protection Act of 2000 (BIPA) provides for several new Medicare benefits and some changes in enrollment policy for Medicare beneficiaries that are effective in CY 2001. Are M+COs required to notify their members of these changes?**

   A: Generally, regulations require M+COs to notify their members of changes in plan benefits at least 30 days in advance of the effective date of the changes. To the extent that it is not possible to provide that advance notice (e.g., in the case of benefits that took effect December 21, 2000) or not reasonable to expect an M+CO to do so (e.g., in the case of new benefits approved so late that 30-day advance notice may not be practical), HCFA will not take any enforcement actions against an M+CO based on a failure to comply with the 30-day advance notice requirement.
   However, to the extent that new benefits become effective on a date that permits M+COs to comply with the usual 30-day advance notice requirement (e.g., changes effective on July 1, 2001), such advance notice must be provided. The statutory benefit changes of which enrollees must be notified are described in more detail in Questions 3 and 4 below. This notification may be given in the letter that the M+CO sends to its members informing them of other changes in plan benefits, if there are such changes. (A model cover letter is available at www.hcfa.gov/medicare/cy2001.htm.) M+COs may also notify their members of

these changes in any subsequent mailings, provided that such notification is given at least 30 days in advance of the effective date of such changes. M+COs can also notify their members of some of these changes in their 2001 Evidence of Coverage (EOC) as described below. Finally, M+COs can use a combination of these methods to notify their members of changes in coverage and enrollment policy.

2. **Q: How should M+COs amend their EOCs to include information about changes in coverage and enrollment policy?**

   A: M+COs that have not yet disseminated their EOCs to members can amend the EOC to describe some of the changes in coverage and enrollment policy under BIPA. The model EOC was distributed as OPL 2000.130 on December 12, 2000, and is available on the HCFA web site at www.hcfa.gov. Model language amending sections 8 and 16 of the model EOC is available on the HCFA web site at www.hcfa.gov/medicare/cy2001.htm. If the M+CO does not amend its EOC to reflect these changes, then it must notify its members of these changes in subsequent mailings as described in Question 1 above.

3. **Q: What are the Medicare coverage changes effective for CY 2001?**

   A: The relevant changes and their citations in the legislation are outlined below:

Section	Provision	Effective Date
Title I, Sec.101	Coverage of screening pap smears and pelvic exams once every two years, as opposed to once every 3 years.	July 1, 2001
Title I, Sec.103	Coverage for screening colonoscopy once every ten years or within 4 years of a screening flexible sigmoidoscopy for all individuals who are not at high risk.	July 1, 2001
Title I, Sec. 112	Coverage of drugs and biologicals that usually are not self-administered.	December 21, 2000*
Title I, Sec. 113	Elimination of time limitation on Medicare benefits for immunosuppressive drugs	December 21, 2000*
Title IV, Sec. 428	Replacement of artificial limbs or parts, if authorized.	April 1, 2001

Title VI, Sec. 621	Home Skilled Nursing Facility (SNF) Benefit (Described in Question 4 below.)	December 21, 2000*

*As noted above, since these provisions were effective on the date of enactment, 30 days advance notice is not possible. Therefore, M+COs must notify their members of these changes as soon as possible. (See Question 4 below regarding the home SNF benefit.)

4. Q: What is the home SNF benefit described in Title VI, Section 621 of BIPA?

A: The Home SNF benefit provides additional choice to the Medicare beneficiary to elect to receive post-hospital services through the following facilities:

- The SNF in which the enrollee resided at the time of admission to a hospital;
- The SNF that provided services through a continuing care retirement community that provided residence to the enrollee at the time of admission to a hospital;
- The SNF in which the spouse of the enrollee is residing at the time an enrollee is discharged from the hospital.

A Medicare enrollee may elect to receive services through one of these facilities only if the facility has agreed to be treated by the M+CO in a substantially similar manner as a similarly situated SNF that is under contract with the M+CO.
This provision is effective only for those M+C plans for which there was no signed contract prior to the enactment of BIPA on December 21, 2000. M+C plan contracts signed before that date are unaffected.

5. Q: What are the changes in enrollment policy (effective in CY 2001) and where can we find more information?

A: The relevant changes and their citations in the legislation are outlined below:

Section	Provision	Effective Date
Title VI, Sec. 619	Allows individuals who enroll in or disenroll from an M+C plan after the 10th day of the month to make the election effective beginning on the first day of the next calendar month.	Applies to elections and changes of coverage made on or after June 1, 2001.
Title VI, Sec. 620	Permits ESRD beneficiaries to enroll in another M+C plan if they lost coverage when their plan terminated its contract or reduced its service area.	Applies to terminations on or after the date of enactment and is also retroactive to include individuals whose enrollment in an M+C plan was terminated involuntarily on or after

		December 31, 1998.

6. **Q: Given the BIPA timeframes and the March 1 effective date for the new M+C payment rates, how quickly will HCFA review marketing materials?**

   A: HCFA's review of M+COs' marketing materials will be conducted concurrently with the ACRP submission review process. However, as with the CY 2001 renewal process, final approval of marketing materials will not be granted until the ACRP has been approved. Thus, any changes to the ACRP may delay review and approval of the plan marketing materials.

7. **Q: The new legislation contains a provision that reduces the period of review time for certain marketing materials. How does this affect the review of cover letters and other marketing materials?**

   A: Under Title VI, Sec. 613 of BIPA, if an M+CO uses, without modification, proposed model language specified by HCFA, then the period of review for those materials is reduced to 10 days. HCFA has 10 days to review and approve or disapprove the marketing material. This provision applies to marketing material submitted on or after January 1, 2001, and therefore includes those materials submitted as a result of an M+CO's changes to its plan benefit package as permitted under BIPA. As specified in BIPA, this reduced time period for review only applies in those instances in which the M+CO uses, without modification, model language as provided by HCFA. With respect to those model letters provided by HCFA for BIPA purposes, the M+CO can only modify the language presented in *italicized* font in order to qualify for the 10-day review period. In addition, the M+CO should notify HCFA at the time that it submits the material for review that it is using the model language without modification. If the M+CO is modifying the language, it should highlight the modifications in its submitted materials. That will help to expedite review.

8. **Q: With respect to those M+COs that choose to return to the M+C Program or re-enter a previously-reduced service area, what materials are they required to send to prospective enrollees?**

   A: Such M+COs must send a new Summary of Benefits (SB) to prospective enrollees, including former members. An Annual Notice of Change (ANOC) is not required. If the M+CO chooses to send the new SB to its former members, then it must also include a cover letter that informs them that the M+CO is returning to the M+C program or is re-entering a previously reduced service area. A model cover letter will be available at www.hcfa.gov/medicare/cy2001.htm.

9. **Q: For administrative purposes and due to the tight timeframes for notifying members, can an M+CO send information about its benefits changes to the same members who received our ANOC or does it need to send the information to its current membership?**

A: Regulations at 42 CFR 422.111(d)(3) require M+COs to notify all enrollees of any changes to their M+C plan. Therefore, the M+CO must send information about its benefit changes to all of its current enrollees.

Enrollment

1. **Q: If a beneficiary elects to join an M+C plan that is open for enrollment (either a new plan or a current plan), when will his/her enrollment be effective?**

   A. M+COs with open M+C plans will be permitted to process enrollments (not disenrollments) for a March 1, 2001 effective date, even if the enrollment form is not received by the M+CO until after February 10, 2001. M+COs are not required to follow this process; they can choose to process enrollments according to the current effective date rules for the Open Enrollment Period (i.e., elections made on or before the 10th of the month are effective the first day of the next month, and elections made after the 10th of the month are effective the first day of the second month following the month in which the election was made.)

   Regardless of the approach taken, M+COs must apply the effective date rules consistently among all potential members for each M+C plan. In addition, M+COs must clearly explain the effective date rules that apply in the cover letter that is mailed to beneficiaries and any enrollment information that accompanies this letter. Model cover letters are available at http://www.hcfa.gov/medicare/cy2001.htm .

   The above exception is only for enrollments made during the month of February. All other voluntary enrollments or disenrollments made after the 10th of the month during the Open Enrollment Period (OEP) in March, April, and May, will not be effective until the first day of the second month following the month in which the election was made. After June 1, 2001, all voluntary elections (both enrollments & disenrollments) made during the OEP will be effective the first day of the month following the month in which the election was made.

2. **Q: What if an M+C plan is closed to accept enrollments?**

   A: Only those individuals who are enrolling in M+C plans that are open AND offering a March 1 effective date may enroll effective March 1. Therefore, if an M+C plan is closed, the plan would not accept enrollments for a March 1 effective date (except in cases of a Special Election Period (SEP) for a permanent move, Employer Group Health Plan (EGHP) SEPs and SEPs for a contract termination, violation or sanction).

3. **Q: What if an M+C plan that was previously closed to accept enrollments in February 2001 wishes to "re-open"?**

   A: M+C organizations may "re-open" to accept enrollments at any time during 2001. If an M+C plan chooses to close enrollment, then plan must notify the general public 30 calendar days in advance of closing the open enrollment process.

4. Q: What if an M+C plan has a HCFA-approved capacity limit?

A: If an M+C plan has a HCFA-approved capacity limit and has reached this limit, the plan must remain closed to all prospective enrollees (with the exception of reserved "age-in" vacancies) until the limit is lifted or vacancies occur within the limit. If an M+C plan has a HCFA-approved capacity limit and has not reached that limit and is open to new enrollment, then the plan can choose to accept enrollments received in February for a March 1 effective date, as described in Question 1 above.

5. Q: How has HCFA implemented Section 620 of BIPA?

A: As a result of section 620, individuals with end-stage renal disease (ESRD) have the right to join a new M+C plan if their plan leaves the Medicare program or stops providing coverage in their area. This applies to all M+C plan non-renewals, terminations, and service area reductions that occurred on or after December 31, 1998.
HCFA has notified affected beneficiaries (http://www.hcfa.gov/medicare/bipa620letter.htm) and has provided instructions to M+COs on section 620 (http://www.hcfa.gov/medicare/systems1.htm). M+COs should process any enrollments pertaining to section 620 as explained in this letter.

6. Q: What happens if a beneficiary does not make a new election before the Special Election Period expires on December 31, 2001? Does he lose his right to join a new M+C plan?

A: No. Although the Special Election Period (SEP) that we created for section 620 expires on December 31, 2001, a beneficiary does not lose his right to join a new M+C plan if he does not enroll in one before then. He will be permitted to join a new M+C plan during any of the other M+C election periods (e.g., the Open Enrollment Period, the November Annual Election Period, or any other SEPs that may apply).

7. **Q: Are beneficiaries who meet the criteria specified in section 620 permitted to join cost plans?**

A: No. Section 620 only pertains to M+C plans. Cost plans are neither required nor permitted to enroll beneficiaries with ESRD who meet the criteria in section 620.